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BEFORE THE BOARD OF PATENT APPEALS AND INTERFERENCES

Application Number: 10/042,236
Filing Date: January 11, 2002
Appellant(s): HALOW ET AL.

Mitchell B. Wasson, Reg. No. 27,408
For Appellant

EXAMINER'S ANSWER

This is in response to the appeal brief filed April 14, 2004.

(1) Real Party in Interest

A statement identifying the real party in interest is contained in the brief.

(2) Related Appeals and Interferences

A statement identifying the related appeals and interferences which will directly affect or be directly affected by or have a bearing on the decision in the pending appeal is contained in the brief.

(3) Status of Claims

The statement of the status of the claims contained in the brief is correct.

(4) Status of Amendments After Final

The appellant's statement of the status of amendments after final rejection contained in the brief is correct.

(5) Summary of Invention

The summary of invention contained in the brief is correct.

(6) Issues

The appellant's statement of the issues in the brief is correct.

(7) Grouping of Claims

Appellant's brief includes a statement that claims 1, 2, 4-15 and 17-21 do not stand or fall together and provides reasons as set forth in 37 CFR 1.192(c)(7) and (c)(8). The Examiner notes that Appellant sets forth the same arguments for independent claims 1 and 13. The Appellant does not set forth any patentable distinctions between independent claims 1 and 13.

(8) Claims Appealed

The copy of the appealed claims contained in the Appendix to the brief is correct.

(9) Prior Art of Record

6,343,271	Peterson et al	1-2002
5,359,509	Little et al	10-1994
6,253,186	Pendleton, Jr.	6-2001
5,253,164	Holloway et al	10-1993
5,930,759	Moore et al	7/1999
6,341,265	Provost et al	1-2002

Kienle, Kenneth, "Clamping Down on Code Creep"

Hartnett-Barry, Joan, "Uninsured Motorist Claims and Fraud: How to Tame a Volatile Mix", Claims Magazine, September, 1999, 7 pages.

(10) Grounds of Rejection

The following ground(s) of rejection are applicable to the appealed claims:

Claim Rejections - 35 USC § 103

1. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

> (a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negatived by the manner in which the invention was made.

2. Claim 1, 2, 6, 7, 9, 10, 13-15, and 19 are rejected under 35 U.S.C. 103(a) as being unpatentable over Peterson et al., Pat. No. 6,343,271 (hereinafter Peterson) in view of Little et al., Pat. No. 5,359,509 (hereinafter Little) and Kienle, Kenneth, "Clamping Down on Code Creep" (hereinafter Kienle).

As to claim 1, Peterson discloses a system for reviewing medical treatment claims provided by a plurality of practitioners to a plurality of insurance entities for the determination of the appropriateness of the medical treatment claims (i.e. adjudicating medical insurance claims)(see abstract), comprising:

a clearing house for receiving information from the plurality of practitioners regarding claims to be paid by one or more of the plurality of insurance entities (i.e. permits health care providers to electronically prepare insurance claims and submit claims to the claims processing system)(col. 6, lines 64-66 and col. 7, lines 6-9), said clearing house provided with software to determine the appropriateness of each of the claims submitted by each of the plurality of practitioners (i.e. a predefined set of adjudication rules are contained in auto adjudication database and provide criteria by which claims are either approved or denied)(col. 9, lines 31-35), said clearing house communicating with the plurality of insurance entities and the plurality of practitioners regarding the appropriateness of each of the claims (i.e. health care provider may use the automated adjudication system to determine whether the claim is to be automatically adjudicated or manually adjudicated ... health care provider may access information regarding the adjudication status of a submitted claim...claims that require manual claims adjudication

are transferred to a claims shop 52 or private contractors employed by insurers 54)(col. 6, line 64 - col. 7, line 13 and col. 9, lines 31-45).

Peterson does not explicitly disclose

wherein said software determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single treatment period of time on a single day.

However, Little discloses wherein said software determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single treatment period of time on a single day (col. 7, lines 10-26). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include said software determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one treatment claim for a single treatment period of time on a single day as disclosed by Little within the Peterson method for the motivation of automatically adjudicating payment requests thereby lowering the costs of health care (col. 3, lines 1-5 and col. 4, lines 45-48).

Peterson and Little do not explicitly disclose

determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single block of treatment time on a single day.

However Kienle discloses determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate

treatment claim for a single block of treatment time on a single day (i.e. incidental and/or multiple procedures)(page 2, lines 18-40 and page 3, lines 10-16). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single block of treatment time on a single day as disclosed by Kienle within the Peterson and Little combination for the motivation of more easily identify questionable surgical claims and mark them for review (see abstract).

Peterson, Little and Kienle do not explicitly disclose

wherein the single practitioner has submitted a medical treatment claim for more than one patient for a single period of time on a single day.

However, the Examiner takes official notice that it was well known in the claims fraud detection arts to flag multiple claims submitted for more than one patient at a single period of time on a single day from a provider. The motivation was to flag claims that would be difficult if not impossible for a provider to legitimately perform. It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include wherein the single practitioner has submitted a medical treatment claim for more than one patient for a single period of time on a single day within the Peterson and Little method for the motivation above.

As to claim 2, Peterson discloses the system in accordance with claim 1, wherein said clearing house pays the proper practitioner once said clearing house has

determined that a particular claim submitted by that practitioner to said clearing house is appropriate (i.e. a claim that has been automatically adjudicated and approved is submitted to a payment system... funds in an amount equal to payment are transferred from pool to a clearinghouse bank after which funds are transferred to the doctor's account)(col. 9, line 62 - col. 10, line 6).

As to claim 6, Peterson discloses the system in accordance with claim 1, wherein said clearing house is provided with a memory containing a list of treatment codes and a list of diagnostic codes (i.e. claim is compared against a database or another system to determine if diagnosis and treatment are consistent)(col. 11, line 66 - col. 12, line 4).

As to claim 7, Peterson discloses the system in accordance with claim 6, wherein said clearing house determines the appropriateness of each claim based reviewing a treatment code with respect to a diagnostic code for a particular patient (i.e. claim is compared against a database or another system to determine if diagnosis and treatment are consistent)(col. 11, line 66 - col. 12, line 4) .

As to claim 9, Peterson discloses the system in accordance with claim 2, wherein said clearing house is paid by the appropriate insurance entity when said clearing house pays the proper practitioner (i.e. funds in an amount equal to payment are transferred from pool established by third party insurer to a clearinghouse bank after which funds are transferred to the doctor's account)(col. 9, line 62 - col. 10, line 6).

As to claim 10, Peterson discloses the system in accordance with claim 1, further including a device for entering data provided at each of the practitioner locations (i.e. doctor terminal 230)(Fig. 10).

As to claim 13, Peterson discloses a method of determining the appropriateness of a treatment claim submitted by one of a plurality of practitioners to one of a plurality of insurance entities, the claimed treatment claim covering a treatment prescribed to a patient based upon a particular diagnosis or condition (i.e. adjudicating medical insurance claims ... diagnosis and treatment are embedded in the claim form as the claim is prepared for submission)(see abstract and col. 9, lines 8-16)), comprising the steps of:

establishing a clearing house for examining each of the treatment claims (i.e. claims adjudication system 48)(Fig. 4);

submitting one or more treatment claims to said clearing house (i.e. permits health care providers to electronically prepare insurance claims and submit claims to the claims processing system)(col. 6, lines 64-66 and col. 7, lines 6-9),;

reviewing each of the treatment claims to determine the appropriateness of each of the treatments (i.e. a predefined set of adjudication rules are contained in auto adjudication database and provide criteria by which claims are either approved or denied)(col. 9, lines 31-35); and

communicating with the appropriate practitioner and the appropriate insurance entity the appropriateness of each of said treatment claims (i.e. health care provider may use the automated adjudication system to determine whether the claim is to be automatically adjudicated or manually adjudicated ... health care provider may access information regarding the adjudication status of a submitted claim...claims that require manual claims adjudication are transferred to a claims shop 52 or private contractors employed by insurers 54)(col. 6, line 64 - col. 7, line 13 and col. 9, lines 31-45.

Peterson does not explicitly disclose

said reviewing step including determining whether a single practitioner has submitted more than one disparate treatment claim for a single treatment period of time on a single day.

However, Little discloses wherein said software determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single treatment period of time on a single day (col. 7, lines 10-26). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include said reviewing step including determining whether a single practitioner has submitted more than one disparate treatment claim for a single treatment period of time on a single day as disclosed by Little within the Peterson method for the motivation of automatically adjudicating payment requests thereby lowering the costs of health care (col. 3, lines 1-5 and col. 4, lines 45-48).

Peterson and Little do not explicitly disclose

determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single block of treatment time on a single day.

However Kienle discloses determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single block of treatment time on a single day (i.e. incidental and/or multiple procedures)(page 2, lines 18-40 and page 3, lines 10-16). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single block of treatment time on a single day as disclosed by Kienle within the Peterson and Little combination for the motivation of more easily identify questionable surgical claims and mark them for review (see abstract).

Peterson, Little and Kienle do not explicitly

wherein the single practitioner has submitted a medical treatment claim for more than one patient for a single period of time on a single day.

However, the Examiner takes official notice that it was well known in the claims fraud detection arts to flag multiple claims submitted for more than one patient at a single period of time on single day from a provider. The motivation was to flag claims that would be difficult if not impossible for a provider to legitimately perform. It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include wherein the single practitioner has submitted a medical treatment claim for

more than one patient for a single period of time on a single day within the Peterson and Little method for the motivation above.

As to claim 14, Peterson discloses the method in accordance with claim 13, including the step of having said clearing house pay the practitioner if said reviewing step indicates that a particular submitted treatment claim was appropriate (i.e. a claim that has been automatically adjudicated and approved is submitted to a payment system... funds in an amount equal to payment are transferred from pool to a clearinghouse bank after which funds are transferred to the doctor's account)(col. 9, line 62 - col. 10, line 6).

As to claim 15, Peterson discloses the method in accordance with claim 14, including the step of having one of the insurance entities pay said clearing house if said reviewing step indicates that a particular submitted treatment claim was appropriate (i.e. funds in an amount equal to payment are transferred from pool established by third party insurer to a clearinghouse bank after which funds are transferred to the doctor's account)(col. 9, line 62 - col. 10, line 6).

As to claim 19. Peterson discloses the method in accordance with claim 13, wherein said reviewing step includes comparing a treatment code included in said treatment claim with a diagnosis code included in said treatment claim (i.e. claim is

compared against a database or another system to determine if diagnosis and treatment are consistent)(col. 11, line 66 - col. 12, line 4).

As to claim 21, Peterson discloses the method in accordance with claim 13, further including the step of obtaining a pre-authorization from one of the insurance entities for the treatment covered by said treatment claim (col. 14, lines 55-56).

3. Claims 4-5 are rejected under 35 U.S.C. 103(a) as being unpatentable over Peterson, Little, and Kienle as applied to claim 1 above, and further in view of Pendleton, jr., Pat. No. 6,253,186 (hereinafter Pendleton).

As to claim 4, Peterson does not explicitly disclose the system in accordance with claim 1, wherein said software determines the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time.

However, Pendleton discloses said software determines the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time (i.e. initial step in system determination process involves reading provider record from daily claims 158 ... each record is analyzed ... provider who submits claims for numerous and expensive services. The expert system may identify the provider as potentially fraudulent)(Fig. 12 and col. 9, lines 35-45). It would have been obvious to one of ordinary skill in the art at the time of

Applicant's invention to include said software determines the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time as disclosed by Pendleton within the Peterson method for the motivation of processing claims and differentiating between fraudulent and non fraudulent providers of medical services (col. 1, lines 27-34).

As to claim 5, Peterson does not explicitly disclose the system in accordance with claim 4, wherein said particular duration of time is one work day.

However, Pendleton discloses said particular duration of time is one work day (i.e. initial step in system determination process involves reading provider record from daily claims 158 ... each record is analyzed ... provider who submits claims for numerous and expensive services. The expert system may identify the provider as potentially fraudulent)(Fig. 12 and col. 9, lines 35-45). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include said particular duration of time is one work day as disclosed by Pendleton within the Peterson method for the motivation of processing claims and differentiating between fraudulent and non fraudulent providers of medical services (col. 1, lines 27-34).

4. Claim 8 is rejected under 35 U.S.C. 103(a) as being unpatentable over Peterson, Little, and Kienle as applied to claim 6 above, and further in view of Halloway et al., Pat. No. 5,253,164 (hereinafter Halloway).

As to claim 8, Peterson does not explicitly disclose the system in accordance with claim 6, wherein said clearing house determines the appropriateness of each claim based upon a determination that a plurality of said treatment codes are mutually exclusive.

However, Halloway discloses said clearing house determines the appropriateness of each claim based upon a determination that a plurality of said treatment codes are mutually exclusive (i.e. the first rules are utilized for multiple records wherein on of the codes may be eliminated for payment approval purposes ... in rule E1, if one code number ACODE appears in the same list of codes as one or more codes BCODE to CCODE, then ACODE is eliminated and the code number appearing within the range BCODE to CCODE is retained ... by first applying rule designated as E1 and E2, it may be possible to eliminate one or more inappropriate codes from consideration)(col. 6). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include said clearing house determines the appropriateness of each claim based upon a determination that a plurality of said treatment codes are mutually exclusive as disclosed by Halloway within the Peterson method for the motivation of providing a cost effective automated system for processing and paying only appropriately coded claims (col. 3, lines 6-10).

5. Claim 11 is rejected under 35 U.S.C. 103(a) as being unpatentable over Peterson, Little, and Kienle as applied to claim 10 above, and further in view of Moore et al., Pat. No. 5,930,759 (hereinafter Moore).

As to claim 11, Peterson does not explicitly disclose the system in accordance with claim 10, wherein said device includes a bar code reader.

However, Moore discloses said device includes a bar code reader (i.e. barcode reader 22)(Fig. 1). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include said device includes a bar code reader as disclosed by Moore within the Peterson method for the motivation of expediting the filing and processing of health care claims (col. 3, lines 27-34).

6. Claim 12 is rejected under 35 U.S.C. 103(a) as being unpatentable over Peterson, Little, and Kienle as applied to claim 10 above, and further in view of Provost et al., Pat. No. 6,341,265 (hereinafter Provost).

7. As to claim 12, Peterson does not explicitly disclose the system in accordance with claim 10, wherein said device includes a keyboard.

However, Provost discloses wherein said device includes a keyboard (col. 7, lines 20-27). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include wherein said device includes a keyboard as disclosed by Provost within the Peterson method for the motivation of enabling a health care provider to enter required information (col. 7, lines 20-27).

8. Claims 17 and 18 are rejected under 35 U.S.C. 103(a) as being unpatentable over Peterson, Little, and Kienle as applied to claim 13 above, and further in view of Pendleton.

As to claim 17, Peterson does not explicitly disclose the method in accordance with claim 13, wherein said reviewing step determines the appropriateness of each treatment claim based upon the total number of claim hours submitted for a particular duration of time.

However, Pendleton discloses said software determines the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time (i.e. initial step in system determination process involves reading provider record from daily claims 158 ... each record is analyzed ... provider who submits claims for numerous and expensive services. The expert system may identify the provider as potentially fraudulent)(Fig. 12 and col. 9, lines 35-45). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include said software determines the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time as disclosed by Pendleton within the Peterson method for the motivation of processing claims and differentiating between fraudulent and non fraudulent providers of medical services (col. 1, lines 27-34).

As to claim 18, Peterson does not explicitly disclose the method in accordance with claim 17, wherein said duration of time is a work day.

However, Pendleton discloses said particular duration of time is one work day (i.e. initial step in system determination process involves reading provider record from daily claims 158 ... each record is analyzed ... provider who submits claims for numerous and expensive services. The expert system may identify the provider as potentially fraudulent)(Fig. 12 and col. 9, lines 35-45). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include said particular duration of time is one work day as disclosed by Pendleton within the Peterson method for the motivation of processing claims and differentiating between fraudulent and non fraudulent providers of medical services (col. 1, lines 27-34).

9. Claim 20 is rejected under 35 U.S.C. 103(a) as being unpatentable over Peterson, Little, and Kienle as applied to claim 13 above, and further in view of Halloway.

As to claim 20, Peterson does not explicitly disclose the method in accordance with claim 13, wherein said reviewing step includes comparing more than one treatment code included in said treatment claim with one another.

However, Halloway discloses said reviewing step includes comparing more than one treatment code included in said treatment claim with one another (i.e. the first rules are utilized for multiple records wherein on of the codes may be eliminated for payment approval purposes ... in rule E1, if one code number ACODE appears in the same list of

codes as one or more codes BCODE to CCODE, then ACODE is eliminated and the code number appearing within the range BCODE to CCODE is retained ... by first applying rule designated as E1 and E2, it may be possible to eliminate one or more inappropriate codes from consideration)(col. 6). It would have been obvious to one of ordinary skill in the art at the time of Applicant's invention to include said reviewing step includes comparing more than one treatment code included in said treatment claim with one another as disclosed by Halloway within the Peterson method for the motivation of providing a cost effective automated system for processing and paying only appropriately coded claims (col. 3, lines 6-10).

(11) Response to Argument

A) The Examiner was using hindsight and Appellant's own disclosure to reach the conclusion that it was legitimate to take official notice of the subject matter initially included in claims 22 and 23 and official notice should not have been taken for this feature.

In response to Appellant's argument that the examiner's conclusion of obviousness is based upon improper hindsight reasoning, it must be recognized that any judgment on obviousness is in a sense necessarily a reconstruction based upon hindsight reasoning. But so long as it takes into account only knowledge which was within the level of ordinary skill at the time the claimed invention was made, and does not include knowledge gleaned only from the Appellant's disclosure, such a

reconstruction is proper. See *In re McLaughlin*, 443 F.2d 1392, 170 USPQ 209 (CCPA 1971). Appellant's arguments directed to Examiner's use of official notice with respect to the feature of "the single practitioner has submitted a medical treatment claim for more than one patient for a single period of time" is nonperuasive. The Examiner notes that the limitation is directed to a specific type of possible fraud activity that the automated system checks claims for. In addition, the Examiner notes that the features of claims 22 and 23 were cancelled and added to independent claims 1 and 13 in an after final amendment. First, the Peterson reference is directed to a system for electronically reviewing medical insurance claims including a check to see if the claim can be automatically adjudicated or if the claim should be manually adjudicated (see abstract). In addition, Peterson discloses that criteria used to determine whether claims should be manually adjudicated vary from insurer to insurer and provides examples of criteria one may use (e.g. unbundling of claims) to determine if a claim should be flagged for manual adjudication (col. 11, line 40 – col. 12, line 28). Therefore, Peterson at least discloses a system that checks the appropriateness of medical claims based on various factors and discloses examples of some specific factors (i.e. unbundling of claims). Furthermore, the Little reference discloses a system that adjudicates medical claims submitted by physicians to insurers and determines the appropriateness of the claims based on user defined review criteria (see abstract). The Little reference provides examples of review criteria such as for multiple surgical procedures performed on the same patient for the same day (col. 7, lines 10-42). In addition, the Little reference explicitly states that the examples used are merely for illustrative purposes that there

are a multitude of review criteria that can be used (col. 7, lines 43-54). Finally, the Kienle reference discloses a computerized system that checks medical claims for questionable claims and marks them for further review. All three references are directed to automated systems that checks for the appropriateness of submitted medical claims and describe examples of specific types of inappropriate claims that the systems check for. The Examiner took official notice it was well known in the fraud detection arts to check claims for the specific condition of "multiple claims submitted for more than one patient at a single period of time on single day from a provider". In other words, the Examiner took official notice that checking for a specific type of inappropriate claim in an automated system that checks for the appropriateness of submitted medical claims was well known in the claims fraud detection arts. The Examiner based his findings on the clear teachings of the Peterson and Little references that disclosed that various factors may be used by the automated to determine the appropriateness of the submitted claims. In addition, the Examiner provided motivation to combine the official notice with the teachings of the Peterson, Little and Kienle combination based on motivation that was found in the Peterson and Little references. Therefore, the Examiner's use of official notice was proper.

B) Even if it was proper to take official notice of the subject matter of cancelled claims 22 and 23, the software required in claim 1 and utilized by the system in claim 13 would have to be drastically altered in the Peterson clearing house.

In response to Appellant's argument that the software required in claim 1 and utilized by the system in claim 13 would have to be drastically altered in the Peterson clearing house, the test for obviousness is not whether the features of a secondary reference may be bodily incorporated into the structure of the primary reference; nor is it that the claimed invention must be expressly suggested in any one or all of the references. Rather, the test is what the combined teachings of the references would have suggested to those of ordinary skill in the art. See *In re Keller*, 642 F.2d 413, 208 USPQ 871 (CCPA 1981). As explained above, Peterson at discloses an automated system that checks the appropriateness of medical claims based on various factors and discloses examples of some specific factors. The Examiner took official notice that checking for a specific type of inappropriate claim in an automated system that checks for the appropriateness of submitted medical claims was well known in the claims fraud detection arts. It is the Examiner's position that one of ordinary skill would have been motivated to combine this factor within the Peterson et al system.

C) The Hartnett-Barry article does not anticipate or suggest a situation in which medical fraud is to be discovered utilizing the software of the present invention when a single practitioner has submitted more than one disparate medical treatment claim for a single block of time for multiple patients.

The Hartnett-Barry reference, the article describes certain factors that might indicate fraud with respect to uninsured motorist claims and also with respect to treatment facilities used by the insured (page 5). In particular, the Examiner focused on the

discussion of the treatment facilities since these are related to medical claims presented by the insured (bottom of page 5). The Hartnett-Barry reference then describes various factors that a claims adjusters uses to determine if a submitted claim is appropriate including the cited portion on page 6 directed to "How many examination and treatment rooms are there? Could three insureds really be treated at the same time?" The Examiner interpreted this section as disclosing the insurance arts use various factors to determine the appropriateness of medical claims including whether multiple patients could be treated at the same time by a physician. The Examiner relied on this teaching only from the Hartnett-Barry reference. The Examiner relied on the combined teaching of Peterson, Little and Kienle to disclose a software based system for determining the appropriateness of medical claims based on various factors. Therefore, all of the limitations of Appellant's claimed invention are disclosed by the combined references and Examiner's use of official notice.

D) Peterson, Little, Kienle and Pendleton, Jr. do not disclose the specific limitations of claims 4, 5, 17 and 18.

The Pendleton reference was relied on by the Examiner to disclose the specific limitations of clams 4, 5, 17 and 18 as noted by Appellant (Appeal brief, page 12). The Pendleton reference discloses a method and system for detecting potentially fraudulent providers of goods and services (see abstract). The system may process claims on a daily basis (col. 5, lines 27-32 and col. 6, lines 4-8 and lines 44-54). The system analyzes claims data and identifies potentially fraudulent activity before payment of

claims is made (col. 1, lines 27-35). The system analyzes the claim(s) submitted by the provider and compares the claim(s) to a predetermined threshold indicator. In addition, Pendleton, Jr. discloses a provider who submits claims for numerous and expensive services and the expert system may identify the provider as potentially fraudulent (col. 9, lines 35-45). Since the system can process claims on a daily basis, the claims that are submitted and analyzed represent the claims submitted that day for each provider. Furthermore, the Pendleton reference's description of numerous and expensive services is related to the number of claim hours claimed by a provider since numerous and expensive services correspond to more total claim hours submitted per provider as compared to providers who submit claims for less expensive and less numerous services. Moreover, the Pendleton system bases its determination on the appropriateness of the claims in this situation on whether an excessive number of expensive claims are submitted by the practitioner. It is this teaching of Pendleton that the Examiner used to combine with the teachings of the Peterson, Little and Kienle references. Therefore, the Pendleton reference in combination with the Peterson, Little and Kienle references disclose the limitations of claims 4, 5, 17 and 18. In addition, Appellant asserts that the claims are directed to a situation in which the appropriateness of claims submitted by a single practitioner is based on determining whether it was physically possible to bill the total number of hours by the practitioner for a duration of time (Appeal Brief, Bottom of page 12 and page 13). The Examiner notes that these features are not recited in the rejected claim(s). Although the claims are interpreted in light of the specification, limitations from the specification are not read into the claims.

See *In re Van Geuns*, 988 F.2d 1181, 26 USPQ2d 1057 (Fed. Cir. 1993). The claim language of claims 4, 5, 17 and 18 are directed to determining the appropriateness of the claims based upon the total hours submitted by a practitioner and the claims do not include any language directed to checking to see if it was physically possible to bill the total number of hours by the practitioner for a duration of time. Therefore, Appellant's argument directed to this feature is nonpersuasive.

For the above reasons, it is believed that the rejections should be sustained.

Respectfully submitted,

Alexander Kalinowski
Examiner
Art Unit 3626

ALEXANDER KALINOWSKI
PRIMARY EXAMINER

Alexander Kalinowski
November 27, 2004

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